STATE OF HAWAII
Department of Human Services
Med-QUEST Division

Going Home Plus (GHP) Referral Form

Date: ____/____/_____

PART 1: REFERRAL SOURCE/AGENCY INFORMATION	
1. Who is referring this member to GHP? ☐ Nursing Home ☐ Hospital ☐ Self ☐ Family/Friend ☐ Medical Provider ☐ Other Referral Source (specify):_____	
2. Referrer Name:	3. Referring Agency (if applicable):
4. Referral Date:	5. Contact Phone Number:
6. Contact Fax Number:	7. Contact E-Mail Address:

PART 2: MEMBER INFORMATION			
8. Member First Name:	9. Member Last Name:	10. MI:	11. Date of Birth: _____/_____/_____
12. Medicaid ID #:	13. Health Plan: ☐ AlohaCare ☐ HMSA ☐ Kaiser ☐ Ohana ☐ United		
14. Current Location/Address:		15. City, State, Zip:	
16. Island: ☐ Oahu ☐ Maui ☐ East Hawaii ☐ West Hawaii ☐ Kauai ☐ Other _____			
Name of Resident's Authorized Representative, if any (Last, First): _____			
Phone Number of Authorized Representative: _____ Email Address of Authorized Representative: _____			

PART 3: MEMBER ELIGIBILITY INFORMATION (Subject to Verification)
All three criteria below have to be met for GHP eligibility
☐ Medicaid and
☐ Approved Level of Care on DHS 1147 or DHS 1150 and
☐ At least 60 <u>continuous</u> days in a hospital, nursing home, ICF-IDD and or rehab facility

GHP Referral Form Instructions

Please fax the first page of this form to the member's health plan with ATTN: GHP Program**.**

AlohaCare Fax: 808-973-7374	**HMSA** Fax: 808-944-5604	**Kaiser** Fax: 808-432-3146	**Ohana** Fax: 855-637-2901	**United** Fax: 844-882-6985
For DDD/DOH: Contact DDD/DOH Case Manager				